

FMS Foundation Newsletter

3401 Market Street suite 130, Philadelphia, PA 19104-3315, (215-387-1865) Vol 3 No. 10

November 1, 1994

Dear Friends,

"...the tide is already being turned...Above all, steady progress in public enlightenment has been forged, over the past two-and-a-half years, by the False Memory Syndrome Foundation..."

Frederick Crews

"The Revenge of the Repressed," Part II

The New York Review of Books, December 1, 1994

Extraordinary developments continue: scholarly articles, retractions, legal decisions, professional guidelines, even a TV series with the FMS issue raised (Sisters). They continue because of the joint efforts of families, retractors and professionals to educate the public and the profession about a terrible problem. The developments continue because the issues we have raised about memory and therapy techniques are important issues. Yes, some critics still cling to their tactics: referring to "so-called false memory syndrome"; insisting that the FMSF is protecting perpetrators; equating our questions about therapy and memory processes to a denial that sexual abuse of children exists; and—most inappropriately—personal attacks on the Director and Advisory Board members. But this is finally beginning to be seen by many professionals as an embarrassment to their field and nothing but an attempt to deflect from self-examination of the issues raised. Whatever our critics may think of particular people, whatever our critics may think politically, the issues of memory and therapy processes must be addressed on their own merits.

Last year, the FMS Foundation records were examined to see if funding came from known perpetrators, "organized Satanists," or the mafia! This year critics seem to think that the Foundation is funding or encouraging lawsuits against therapists. At one recent conference in Washington, a lawyer noted publicly that her group expects to use the RICO act to bring lawsuits against the Foundation. Isn't that for organized crime? We do hope that our critics will come to the "Memory and Reality: Reconciliation" conference in Baltimore on December 9-11 to learn first-hand about the issues of concern to the Foundation and to learn about memory from a collection of the most noted and respected memory experts in the world.

The discussion at the conference is sure to be lively. On October 25, in the *New York Times* Science Section, an article appeared with the title, "New Kind of Memory Found to Preserve Moments of Emotion." We have reprinted this article by Dan Goleman which reports on the work of Cahill, Prins, Wever & McGaugh in a Letter to *Nature*, Vol 371, No 6499, pp 702-704, October 10, 1994. Does this research suddenly change

what is known about memory? Does this research really justify the conclusion that traumatic memories involve different processes? Science can be more exciting than a mystery story. Which arguments and which research will withstand scrutiny and what will it mean? The answer to these questions must be in the hands of memory researchers who specialize in neurobiology because the experiments deal with the administration of drugs. Lay readers can note:

(1) The type of research reported is "laboratory" research which traumatists such as Lenore Terr, M.D. or Judith Herman, M.D. have said is irrelevant. If traumatists do embrace this research, they must also embrace other laboratory research and weigh scientific evidence with the rest of us. Science is principled—the rules of what is accepted as evidence must be consistent.

(2) The research does not deal with the problem of what is "traumatic" to a person. (The subjects in this research found the stimuli slides only moderately traumatic.)

(3) The research notes particularly why traumatic memories are remembered. "Psychologists have said for decades that motivation is important for learning," said Dr. McGaugh. "We'd say excitement is important. In my judgment, it would do no harm to make learning more exciting." At the same time, McGaugh believes the results suggest that, "it might be possible to mute the formation of [traumatic] symptoms by inactivating this system."

(4) The research says nothing about the claims in the reports to the Foundation of amnesia for decades and amnesia for hundreds of different experiences.

(5) This research says nothing about accuracy of memories. The best available scientific evidence indicates that all memories, traumatic or not, are subject to the same ordinary processes of misperceptions, distortions, decay and change. A constant in research with memory is its extreme malleability.

(6) Finally, this research says nothing about false memories, for the simple reason that it was studying not false but true memories.

It's not often in life that we get to examine the actual "doing of science" at this level. For all the recent tragedy, for all the pain and the loss, our misguided children gave us much love and happiness as they grew, and they have now given us a first row seat on some of the most exciting science developments in this century. While they may have broken our hearts, our children's mistakes have surely expanded and enriched our minds as we have tried to understand what happened to them.

Pamela

"In the end, everyone benefits from a policy which deters false accusations and encourages true accusations."

Alan Dershowitz, October, 1994

Inside

Australian Psychological Society	3
Stan Abrams	6
August Piper	7
Maria Meyers	8
Jaye Sharp	11
Daniel Goleman	12
Legal Corner	13
Conference Program	16

International Conference

Memory and Reality: Reconciliation

CoSponsored by The False Memory Syndrome Foundation
and The Johns Hopkins Medical Institutions
Baltimore, MD December 9, 10, 11 1994
Registration in order of application receipt.

Become part of the solution to the False Memory problem.

AN INTERESTING DECISION:**State must establish validity of memory repression**

"Before testimony of the victim's memory of the alleged assault may be admitted, a hearing shall be held at which the burden shall be upon the State to establish that the phenomenon of memory repression and the process of recovery through therapy have gained general acceptance in the field of psychology. The State must establish the validity of the phenomenon and process by demonstrating that the reasoning or methodology underlying the testimony is scientifically valid; and that it is capable of empirical testing and can properly be applied to the facts in issue. (See *Daubert v. Merrill-Dow pharmaceutical, Inc.* supra, at page 2796)"

The State of New Hampshire Superior Court, Northern District
September 13, 1994 No. 94-s-45 thru 47 and No. 93-s-1734

The New Hampshire decision above is likely to be widely discussed in coming months. Researchers, clinicians, families, lawyers*—all will be wondering how it will affect the recovered memory discussion.

Scientific Reasoning: What is meant by scientific reasoning and empirical testing in this context? It seems almost ironic that we heard of the recent death of Sir Karl Popper at the same time that we received the New Hampshire decision. Popper, philosopher of science, had a profound influence on scientific thinking because of his observation that while scientific "laws" cannot always be verified, they can be shown to be false. A scientific proposition is one in which it is possible to show that it could be false. This marks a difference between *belief* in something and *science*.

The argument of being able to be falsified is a stumbling block in the discussions of recovered memory therapy. Accused parents have no way to falsify the accusations. While researchers feel that the ability to show that something can be false is a necessary condition for it to be scientific, non-researchers often think that this aspect of science is neither important nor necessary for the practice of therapy. What will the court determine?

Is scientific reasoning relevant to repression? In a long review that appeared in the May 12 edition of *The New York Review of Books*, Thomas Nagel argued that it is not the scientific method that is relevant when it comes to believing in Freudian theory, but instead, the theory's ability to provide explanations for the otherwise mysterious. Of course, Nagel is entirely correct. The scientific method is irrelevant not just when it comes to believing Freudian theories but all sorts of theories. It is always their ability to provide explanations that compels belief. To illustrate the breadth of Nagel's observation, consider the two columns below. The first is his original application.

* In preparation for a possible appeal to the NH Supreme Court, attorney Maggionto is attempting to ascertain the successes or failures of other litigants who have attempted to preclude testimony based upon recall of allegedly repressed memories. If you have any information concerning any case where court had either admitted or denied testimony based on Daubert, please contact Paul Maggionto (1-800-427-1109) or Michael Iacopino (1-603-668-8300).

Original Application

For most of those who believe in the reality of repression and the unconscious, whether or not they have gone through psychoanalysis, the belief is based not on blind trust in the authority of analysts and their clinical observations but on the evident usefulness of a rudimentary Freudian outlook in understanding of ourselves and other people, particularly erotic life, family dramas and what Freud called the psychopathology of everyday life. Things that would otherwise surprise us do not; behavior or feelings that would otherwise seem simply irrational become nevertheless comprehensible. You feel miserable all day, and then discover that it is the forgotten anniversary of the death of someone who was important to you; you find yourself repeatedly becoming absurdly angry with certain women in your professional life, and come to realize that your anger is a throwback to a childhood struggle with your mother. In the end, if we are to believe that Freud was getting at the truth, we must be able in some degree to make use of his approach ourselves. Since controlled and reproducible experiments are impracticable here, the kind of internal understanding characteristic of psychoanalysis must rely on the dispersed but cumulative confirmation in life that supports more familiar psychological judgments.

Another Application

For most of those who believe in the reality of astrology and the occult, whether or not they have had a good horoscope, the belief is based not on blind trust in the authority of astrologers and their clinical observations but on the evident usefulness of a rudimentary astrological outlook in understanding of ourselves and other people, particularly love life, financial affairs and what Nancy Reagan called the orderly running of the country's life. Things that would otherwise surprise us do not; behavior or feelings that would otherwise seem simply irrational become nevertheless comprehensible. You feel miserable all day, and then discover that it is the day of the conjunction of the third house and the fifth planet; you find yourself repeatedly becoming absurdly angry with certain women in your professional life, and come to realize that your anger is a natural consequence of the opposition of your signs. In the end, if we are to believe that astrology is getting at the truth, we must be able in some degree to make use of this approach ourselves. Since controlled and reproducible experiments are impracticable here, the kind of cosmic understanding characteristic of astrology must rely on the dispersed but cumulative confirmation in life that supports more familiar astrological judgments.

How is a belief in repression (the kind of repression theory that allows for memories of space alien abduction, past lives and intergenerational satanic conspiracies) different from a belief in astrology? It will be different only if scientific reasoning and empirical testing apply.

The Australian Psychological Society Limited
Guidelines Relating to Recovered Memories
 October 27, 1994

A CODE OF PROFESSIONAL CONDUCT

The Australian Psychological Society Code of Professional Conduct sets forth principles of professional conduct designed to safeguard

- the welfare of consumers of psychological services
- the integrity of the profession

The General Principles of the Code are:

I Responsibility

Psychologists remain personally responsible for the professional decisions they make

- Psychologists are expected to take cognizance of the foreseeable consequences of their actions and to make every effort to ensure that their services are used appropriately.
- In working with organizations, whether as employees or consultants, psychologists shall have ultimate regard for the highest standards of their profession.

II Competence

Psychologists shall bring to and maintain appropriate skills and learning in their areas of professional practice.

- Psychologists must not misrepresent their competence, qualifications, training or experience.
- Psychologists shall refrain from offering or undertaking work or advice beyond their professional competence.

III Propriety

The welfare of clients, students, research participants and the public, and the integrity of the profession, shall take precedence over a Psychologist's self-interest and over the interests of the psychologist's employer and colleagues.

- Psychologists must respect the confidentiality of information obtained from persons in the course of their work as psychologists. They may reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Psychologists must inform their clients of the legal or other contractual limits of confidentiality.
- Psychologists shall refrain from any act which would tend to bring the profession into public disrepute.

B GUIDELINES RELATING TO RECOVERED MEMORIES

These guidelines set forth conclusions and recommendations designed to safeguard psychologists and clients who are dealing with reports of recovered memories.

I Scientific Issues

Memory is a constructive and reconstructive process. What is remembered about an event is shaped by what is observed of that event, by conditions prevailing during attempts to remember, and by events occurring between the observation and the attempted remembering. Memories can be altered, deleted, and created by events that occur during

and after the time of encoding, and during the period of storage, and during any attempts at retrieval.

Memory is integral to many approaches to therapy. Repression and dissociation are processes central to some theories and approaches to therapy. According to these theories and approaches, memories of traumatic events may be blocked out unconsciously and this leads to a person having no memory of the events. However, memories of these traumatic events may become accessible at some later time. Although some clinical observations support the notion of repressed memories, empirical research on memories generally does not. Moreover the scientific evidence does not allow general statements to be made about any relationship between trauma and memory.

"Memories" that are reported either spontaneously or following the use of special procedures in therapy may be accurate, inaccurate, fabricated, or a mixture of these. The level of belief in memory or the emotion associated with the memory does not necessarily relate directly to the accuracy of the memory. The available scientific and clinical evidence does not allow accurate, inaccurate, and fabricated memories to be distinguished in the absence of independent corroboration.

Psychologists should recognize that reports of abuse long after the alleged events are difficult to prove or disprove in the majority of cases. Independent corroboration of the statements of those who make or deny such allegations is typically difficult, if not impossible. Accordingly, psychologists should exercise special care in dealing with clients, their family members, and the wider community when allegations of past abuse are made.

II Clinical Issues

Psychologists should evaluate critically their assumptions or biases about attempts to recover memories of trauma-related events. Equally, psychologists should assist clients to understand any assumptions that they have about repressed or recovered memories. Assumptions that adult problems may or may not be associated with repressed memories from childhood can not be sustained by available scientific evidence.

Psychologists should be alert to the ways that they can shape the memories reported by clients through the expectations they convey, the comments they make, the questions they ask, and the responses they give to clients. Psychologists should be alert that clients are susceptible to subtle suggestions and reinforcements, whether those communications are intended or unintended. Therefore, psychologists should record intact memories at the beginning of therapy, and be aware of any possible contagion effects (e.g., self-help groups, popular books).

Psychologists should be alert to the role that they may play in creating or shaping false memories. Equally, psychologists should be alert not to dismiss memories that may be based in fact. At all times, psychologists should be empathic and supportive of the reports of clients while also ensuring that clients do not jump to conclusions about the truth or falsity of their recollections of the past. They should also ensure that alternative causes of any problems that are reported are explored. Psychologists should recognize that the context of therapy is important as is the content.

Psychologists should not avoid asking clients about the possibility of sexual or other abusive occurrences in their past, if such a question is relevant to the problem being treated. However, psychologists should be cautious in interpreting the response that is given. Psychologists should never assume that a report of no abuse is necessarily indicative of either repressed or dissociated memory or denial of known events. Nor should they assume that a report of abuse indicates necessarily that the client was abused.

Psychologists should understand clearly the difference between narrative truth and historical truth, and the relevance of this difference inside the therapy context and outside that context. Memory reports as part of a personal narrative can be helpful in therapy independent of the accuracy of those reports. However, to be accepted as actual history, those reports should be shown to be accurate. Psychologists should seek to meet the needs of clients who report memories of abuse, and should do this quite apart from the truth or falsity of those reports. Psychologists should recognize that the needs and well-being of clients take precedence and should design their therapeutic interventions accordingly.

III. Ethical Issues

Psychologists treating clients who report recovered memories of abuse are expected to observe the Principles set out in the Code of Professional Conduct of the Australian Psychological Society, and in the Code of Professional Conduct of the Psychologists' Registrations Boards in States in which they are registered as psychologists. Specifically, psychologists should obtain informed consent at the beginning of therapy in relation to the details of the therapeutic process and its possible consequences.

Psychologists should inform any client who recovers a memory of abuse that it may be an accurate memory of an actual event, may be an altered or distorted memory of an actual event, or may be a false memory of an event that did not happen. Psychologists should explore with the client the meaning and implications of the memory for the client, rather than focus solely on the content of the reported memory. Psychologists should explore with the client ways of determining the accuracy of the memory, if appropriate.

Psychologists should be alert particularly to the need to maintain appropriate skills and learning in this area, and should be aware of the relevant scientific evidence and clinical standards of practice. Psychologists should guard against accepting approaches to abuse and therapy that are not based in scientific evidence and appropriate clinical standards. Psychologists should be alert also to the personal responsibility they hold for the foreseeable consequence of their actions.

IV. Legal Issues

Psychologists should be aware that some approaches and writings concerning abuse and recovered memories urge clients to engage in legal action against the alleged abuser and any others who may question the accuracy of any recovered memories. Psychologists should recognize that their responsibilities are to the therapeutic needs of clients, and not to issues of legal action or revenge. Given

that the accuracy of memories cannot be determined without corroboration, psychologists should use caution in responding to questions from clients about legal action.

Psychologists should be aware that their knowledge, skills, and practices may come under close scrutiny by various public and private agencies if they are treating clients who recover memories of abuse. Psychologists should ensure that comprehensive records are maintained about their sessions with clients who recover memories of abuse.

Psychologists should in no way tolerate, or be seen to tolerate, childhood or adult sexual abuse, or abuse of any kind. They should ensure that their psychological services are used appropriately in this regard, and should be alert to problems of deciding whether allegations of abuse are true or false. They should be alert especially to the different demands and processes of the therapeutic and legal contexts in dealing with such allegations.

V. Research Issues

Psychologists should be aware that research is needed to understand more about trauma-related memory, techniques to enhance memory, and techniques to deal effectively with childhood sexual abuse. Psychologists should support and contribute to research on these, and related, issues whenever possible.

Note—These guidelines have been adapted from: McConkey, K.M., & Sheehan, P.W. (in press) *"Hypnosis, Memory, and Behaviour in the Forensic Setting"* New York: Guildford Press.

MONITORING ALSO NEEDED

Probably most FMSF families are relieved to see the publication of guidelines about recovered memories. At the very least, such guidelines afford our children the opportunity to compare their own therapy experience with the standards of the profession. For this we thank professionals.

Will these guidelines also do the job of improving practice? While such guidelines are obviously necessary, they are not sufficient. In addition to guidelines, there must be the establishment of effective monitoring procedures. We report examples where guidelines were not enough.

The first example of a monitoring problem comes from the October 3, 1994 issue of *Alberta Report* (Canada) where Celeste McGovern writes of outrageous cases in which professionals were involved in court cases. In one of these cases, the judge actually noted that "the evidence of the witnesses...was scary and unprofessional." Their therapy was "almost a brainwashing procedure." The accused people (fathers with young children) in these cases did not have enough money left after their defenses to bring lawsuits for false accusations. They did, however, believe that the therapists should be held accountable for their actions. These fathers filed complaints with the Psychological Association of Alberta.

According to the *Alberta Report* author, "The PAA inquest was immediately closed to the public, unexpectedly brief, and refused to hear damning evidence. The psychologists were completely exonerated by the three-member

panel, whose reasons for the decision will not be disclosed. For fathers falsely accused of sexual abuse by the...psychologists, the decision was the final insult. For many psychologists, including those absolved, it was a victory licensing them to continue controversial sex abuse 'therapy.' But for critics within the mental health industry, the...hearings demonstrate something gravely awry. Psychology, they say, has become a grossly unregulated business..."

A second example typifies the problem faced by families in the United States when they try to get a problem situation examined. Note that the psychologists' Code of Ethics states that, "As practitioners, psychologists know that they bear a heavy social responsibility because

their recommendation and professional actions may later alter the lives of others. They are alert to personal, social, organizational, financial, or political situations and pressures that might lead to misuse of their influence." Psychologists have a fine code, but doesn't the systematic refusal to hear complaints by affected parents nullify this particular part of the code?

Under the current monitoring restrictions in Oregon, for example, there seems to be no way that a monitoring board can check up on a psychologist after the license is given unless the psychologist agrees to open his or her records. From reports that we have received, if the Board of Psychology Examiners notes in the license exam that a psychologist should improve skills in a particular area such as differential diagnosis, there appears to be no way that the Board can determine at a later date if this recommendation was followed. In other words, while guidelines and ethics codes are improving and are very welcome, it is still the case that the current monitoring of mental health professionals is inadequate. To improve this aspect of the mental health field is essential. To do less is to undermine the efforts and credibility of all competent, ethical and caring mental health professionals.

Because monitoring is so ineffective, indeed, virtually non-existent, people with complaints resort to lawsuits. In 1995, a line of lawsuits involving satanic ritual abuse brought by former patients are scheduled to be heard.

NEWS CLIPS

The Independent (London), October 17, 1994

THERE'LL BE THE DEVIL TO PAY:

THE FUTURE OF AMERICA'S RECOVERED MEMORY MOVEMENT IS AT STAKE IN A \$35M LAWSUIT.

"After seven years in therapy, in and out of hospitals until February 1992, Kathryn Schwiderski [who entered therapy for mild depression] is divorced and has no contact with her husband, children, grandchildren, sister or parents. She was subjected to criminal investigation and interrogation and reported to the Child Protection Services, she says, without any evidence. She became convinced she was a member and victim of a satanic cult since her childhood and that she sexually and physically abused her own children;

now she believes the memories were false, implanted by therapists through hypnotism and drugs. She continues to experience extreme emotional problems."

Dennis Schwiderski, Texas oil company executive, was "investigated by a grand jury for allegedly abusing his son, but the case was not pursued, he says, because there was no evidence against him." He is trying to find one of his children, Kelly 23, who has disappeared and believed to be hiding. She apparently still believes she was a member and victim of a cult.

The family contends that "therapists created false memories as part of a scheme to collect millions of dollars in fees for treatment of non-existent abuse at the hands of a satanic cult." The case will go to trial

next year. "The defendants include some of America's leading exponents of recovered memory techniques. They are Judith Peterson, a psychologist from Houston, who first treated the family; Roberta Sachs, a psychologist from Illinois; and Bennett Braun, an Illinois doctor who specializes in multiple personality disorder. The family members are also suing the hospitals where they were treated. In total, there are 25 defendants. Not all face every allegation, but all are defending the action."

"Over the years, Dennis was sent bills totaling \$2 million — health insurance covered most of it."

"All the defendants have filed a defense denying the allegations without detailing their arguments, as is common in US courts. They stand by the therapists' diagnosis that the Schwiderski family were members of a satanic cult and therefore their treatment was justified."

Proof Lacking for Ritual Abuse by Satanists

Daniel Goleman

New York Times, October 31, 1994

"In a survey of more than 11,000 psychiatric and police workers throughout the country, conducted for the National Center on Child Abuse and Neglect, researchers found more than 12,000 accusations of group cult sexual abuse based on satanic ritual, but not one that investigators had been able to substantiate." Dr. Gail Goodman, a psychologist at the University of California at Davis directed the survey."

"The survey found that there was not a single case where there was clear corroborating evidence for the most common accusation, that there was 'a well-organized inter-generational satanic cult, who sexually molested and tortured children in their homes or schools for years and committed a series of murders,' Dr Goodman said."

"Many psychotherapists who have been vocal about a supposed epidemic of sexual abuse by well-organized satanic rings have grown more cautious of late. 'There's clearly been a contagion, a contamination of what people say in therapy because of what they see on TV or read about satanic ritual abuse,' said Dr. Bennett Braun, a psychiatrist who heads the Dissociative Disorders Unit at Rush-North Shore Medical Center in Chicago."

Polygraph Study

"False Memory Syndrome vs Total Repression"

to appear: For the Defense

Stan Abrams, Ph.D., Portland, Oregon

Polygraph results of alleged sexual abusers when no repression was involved (N=300) were compared with the results of alleged sexual abusers when the victims assumedly repressed the memory (N=46). Both groups of tests were defense-attorney referred. The only difference was that in the group of alleged offenders in which the accuser "repressed" the abuse, the act was supposed to have taken place twenty or thirty years ago. Polygraphers would agree that when the act was committed is inconsequential compared to the fact that any punishment for the crime will be carried out in the present. Therefore, subjects involved in crimes committed years ago could be expected to be equally as fearful of detection as those accused of contemporary crimes.

The results showed that in the group of alleged offenders in which repressed memory was involved, 4% of the subjects were found to be deceptive (N=2). In the group of alleged offenders in which memories of the accusers were not repressed, 78% were classified deceptive (N=234). The difference is striking and will surely spur more research in this area. Contact author for information: 503-221-0632.

News from Dublin, Ireland

We have been informed that a scandal seems to be developing in Ireland. One aspect of the problem involves complaints from seven fathers who all claim that they were falsely accused of sexually abusing their children by one particular doctor. The controversy includes the question of the number of reported cases of incest. On the one hand, the official figures of the Garda Commissioner's reports on Crime, from 1986 to 1991 show that there have only been 14 convictions for the crime of incest and 20 convictions for defilement of children. On the other hand, the center at which the doctor in question was employed received government funds to treat hundreds of incest offenders during this time period. An investigation is underway.

USA Today, October 6, 1994, 3A

"A 22-year-old Cincinnati woman who says she has 10 personalities has accused bus driver Joseph Howard, 47, of sexual assault. Two of the personalities say she consented. Howard says he never touched her. His lawyer wants to depose the personalities for trial."

News from Australia

The Australian False Memory Association has now been formally organized. The links between the AFMA and Australian professionals seem strong and the fact that the Australian Psychological Society has already established guidelines for recovered memory situations indicates a positive and determined approach by professionals to deal with the problem.

A letter from Dr. Jerome Gelb, a psychiatrist in Australia,

affirms this optimism. He states, "I am writing to keep you up to date with events in Australia regarding FMS and Recovered Memory Therapy. Australian Psychiatrists are, apart from very few exceptions, fully aware of the iatrogenesis of so-called repressed memories, MPD and Satanic Abuse. The Royal Australian and New Zealand College of Psychiatrists has been helpful in publishing on the issue."

Dr. Gelb mentioned the television and newspaper articles that have recently appeared in Australia noting that they understand the iatrogenic nature of some memories. Dr. Gelb said that he had published a detailed letter to the Editor in the December 1994 RANZCP Journal of Psychiatry and that the journal of Australasian Psychiatry, Vol 2, No 4, August 1994, pp 179-180 had published his article, "Reality Revisited."

Dr. Gelb went on to write that, "I feel that public opinion in Australia is supportive and the media is also. Most importantly, Australian Psychiatrists are almost universally wary of American therapy fads and are highly critical of poorly trained therapists and the inappropriate use of suggestion, persuasion and memory recovery techniques of all kinds. Please let your membership know of these developments."

Articles of Special Interest

International Journal of Clinical and Experimental Hypnosis XLII No 4 October 1994 Special Issue: Hypnosis and Delayed Recall: Part 1 Single issue is \$17.00.

Sage Publications, Inc.; fax/order line: 805-499-0871

Articles by: Mulhern; Spence; Ceci, Loftus, Leichtman & Bruck; Frankel; Kihlstrom; Nash; Garry & Loftus; Erdelyi; Ofshe & Singer; Spiegel & Schefflin; Spanos, Burgess & Burgess.

(***Especially note Frankel article reviewing research on "flashbacks" and Mulhern article with historical focus.)

Frederick Crews. "The Revenge of the Repressed" Part I and Part II. *The New York Review of Books*. November 17, 1994 and Part II December 1, 1994.

Richard Gardner, MD. "You're not a Paranoid Schizophrenic—You only have Multiple Personality Disorder." *Academy Forum*, Vol 38, No 3, Fall 1994, pp 11-14.

Russell Powell & Douglas Boer. "Did Freud mislead patients to confabulate memories of abuse?" *Psychological Reports*, 1994, 74, 1283-1298.

ATTENTION ALL:

To be as cost-effective as possible, the FMSF newsletter is sent out by bulk rate mail. This class of mail will not be forwarded. If you move and do not give us a change of address, you will not receive your newsletter. Please notify us of any change of address 2 weeks before the change takes place. The Foundation can not be responsible for issues that you have missed because you have failed to give us a change of address.

PSYCHOTHERAPIES: VALIDATED AND UN

August Piper, M.D.

The False Memory Syndrome Foundation has recently begun to note that recovered-memory therapy is an unvalidated form of psychotherapy, implying that such therapy is experimental (see page one of the October Newsletter). Though the concerns leading to these criticisms are understandable, attempts to make such implications oversimplify a complicated problem.

In scientific terminology, if something is valid, it does what it is supposed to do. Thus, a validated therapy effectively treats the condition it is intended to treat. As correctly noted in the October newsletter, investigators have measured the effectiveness of various talk therapies. However, such measurement is extraordinarily difficult, for several reasons.

Psychotherapy is severely hobbled by a distressing lack of agreement among its practitioners on the answers to several critical questions. First is the question of what the goals of treatment are. Does the therapist intend simple symptom relief, recovery and reliving of past stressors, insight into the causes of the patient's problems, change in maladaptive behaviors, a thorough remaking of the personality, or what? Second, what criteria should be used to measure improvement? Measuring psychotherapy-induced change is a minefield of difficulty. Third, how much time should treatment require? Some therapists seriously recommend compressing an entire treatment course into a single session, whereas at the other extreme, treatment has endured in some cases for years. I have even heard of one patient who was in analysis for thirty (!) years.

Another difficulty is that psychotherapy has failed to adopt a uniformly-accepted method of classifying and designating the conditions it is concerned with. Such a system of classifying and arranging disorders is called a nosology. The Diagnostic and Statistical Manual, now in its fourth edition (DSM-IV), represents a good start toward such a nosology. However, it is only a start; DSM shows particular problems in classifying disorders that are treated by psychotherapeutic methods (as opposed to pharmacological ones).

In the absence of a good nosology, attempting to do psychotherapy research becomes an arduous, frustrating undertaking. This is true because the symptoms of psychological conditions overlap so much. For example, depression is a very common symptom of all psychological disorders. In some, depression is the legitimate focus of therapy: it is the problem. In others, however, the very same symptom picture results from any or all of a host of other conditions: drug or alcohol use; marital, social, or economic problems; medical conditions; other psychiatric disorders; childhood stressors; etc. Determining the "real" cause of the depression can be nearly impossible—witness the acrimonious debate over those therapists who claim that childhood sexual

abuse is the real cause of many, if not all, adult psychiatric problems, including depression. This overlap, in turn, means that researchers can never be sure that their study groups differ only in the variable under study.

With so many problems and so much disagreement within the field, and with no formal arrangements for those outside the discipline to establish standards for psychotherapy, no one should be surprised that poorly-validated treatments for psychological problems periodically, like locusts, overrun psychotherapy. Counting the protuberances of a patient's head (phrenology); believing that runaway black slaves have a disease (drapetomania); passing magnets over the body (mesmerism); spraying patients with water, or putting them in wet packs or rapidly-rotating chairs; believing that a woman can have excessive envy of the penis, or develop a wandering uterus (hysteria); surgically attacking the brain (lobotomies)—all have had their days in the sunlight.

My purpose here is neither to make excuses for psychotherapy's problems, nor to attack the discipline, but rather to point out how difficult it is to validate therapies. The reader who recognizes this will not think an unvalidated therapy is necessarily a bad therapy: because it is so difficult to prove that a given psychological treatment is effective, many commonly-used psychotherapies are unvali-

dated. Nor will the reader fail to realize that saying a therapy is valid does not go far enough: the question should be, "For which conditions is it valid?"

After all the above is said, however, the essential points made in last month's newsletter article remain correct: many investigators have carefully gathered evidence documenting that one or another treatment, if performed properly, helps patients. In other words, these psychotherapies have been validated. Also, instruction manuals for several different types of psychotherapy are available to practitioners. The manuals are intended to insure that the therapy is performed properly.

Many patients, who have disorders treatable by validated psychotherapies, see recovered-memory practitioners instead. These practitioners have recently come under increasing fire because of the harm their treatments can do. Therefore, the question must indeed be asked: with so many better choices available, why would anyone see therapists who practice a form of treatment that can do such harm? People considering psychotherapy are well advised to spend a few minutes, either on the telephone or in person, to find out whether the clinician utilizes a kind of therapy that has reasonable evidence for efficacy. The list in last month's newsletter might be helpful.

August Piper Jr. M.D. is a psychiatrist in private practice in Seattle, Washington. He is a member of the FMSF Scientific and Professional Advisory Board.

*The purest treasure mortal times afford
Is spotless reputation: that away,
Men are but gilded loam or painted clay.
A jewel in a ten-times-barr'd-up chest
Is a bold spirit in a loyal breast.
Mine honor is my life; both grow in one;
Take honor from me, and my life is done:*

Richard II Act I Scene 1

FROM OUR READERS

MAKE A DIFFERENCE

This is a new column that will let you know what people are doing to challenge the FMS madness. Remember that three years ago FMSF didn't exist. A group of 50 or so people found each other and today we are over 15,000. Together we have made a difference. How did this happen?

YOUR LETTERS HAVE MADE A DIFFERENCE

•The Governor of Washington will be reviewing Paul Ingram's case on December 1, 1994. Many are demanding a full pardon. (Larry Wright wrote about Paul in *Remembering Satan*.)

•In Washington, families go about the state picketing in a mobile home and utility trailer. In Olympia at Evergreen Community College, their utility trailer (parked on campus property) was destroyed by arson. The contents, professionally made picket signs, etc. were all lost. The college was shocked! It seems that free speech appeals to some people only when they agree with the message.

•The Illinois FMS Society sponsored a booth at the Senior Fair held at the College of DuPage. Information was handed out to more than 5,000 people. This is an excellent way to inform and educate.

•Many Wisconsin families wrote to University and State officials to protest the fact that University of Wisconsin sponsored conference on Child Sexual Abuse and Incest did not properly balance their program. They invited an "adult survivor," as keynote speaker but did not also include a "retractor" to warn of dangers. Last year this conference eliminated all vendor booths rather than allow FMSF material. Maybe next year a retractor will be invited.

•Helen, Geraldine and Ben Barr were on Donahue to discuss Geraldine's new book, "My Sister Roscanne." We all recognize how difficult it is to make ourselves vulnerable in front of others, much less a national TV audience. The audience consisted of 121 people, who prior to the show were unaware of the topic of conversation or the guests. This was a relatively unbiased studio audience. Following the taping three people identified themselves to Helen as suffering the heartbreak of a family member with FMS. This demonstrates again that we are probably seeing only the tip of a "horrible and dangerous iceberg."

•Several people reminded us that families should inquire to see if their employers have a matching gift program. This is a good way to support the FMS Foundation. (Most United Way programs will arrange to have donations sent to FMSF too.)

•JANUARY IS FMS MONTH at a university library in Ontario. A special display of all the new books that relate to recovered memory therapy is in preparation. Why not ask your local library to display these important new books?

You can make a difference. Please send me any ideas that you have had that were or might be successful so that we can tell others. Write to Katie Spanuella c/o FMSF.

A Retractor's Question: DOES IT HAVE TO GET WORSE BEFORE IT GETS BETTER? by "Maria Meyers"

What ever happened to the mental health theme of working through the problems of the present and focusing on the future? I believe many people enter therapy because they are concerned about today and want to think in a more positive manner. It appears to me that those basic facts are totally ignored and perhaps even scoffed at by many therapists practicing repressed memory therapy. With the aid of hypnosis and medications, patients are suddenly finding themselves focused for months or even years on past "memories," and they are certainly not positive.

The impending prognosis is not good. The retractors I have spoken to say that their former therapists told them that they would have to get worse before they could get better. I am also a retractor and was told this many times. It didn't mean getting a little more confused or a little more depressed. It meant nearly going insane. It meant retrieving memories so horrid and terrifying I couldn't eat or drink and ended up on IV's. Then I was told that it is normal to have this reaction when recalling "repressed memories."

This belief is tragic. People are losing families, friends, jobs, and their homes. They are filing for bankruptcy after spending months in hospitals. The depression deepens, the present is unbearable, the future looks hopeless and any former beliefs of a happy childhood have been stripped away. In working so hard with their doctors to "get worse in order to get better" some people give up. They cannot endure one more day with the pain, the constant sadness and the fear from torture they see in their mind. Some people commit suicide.

I was deeply moved during the past two weeks when I talked about this subject with four other retractors. These four retractors knew a total of seven people in this kind of therapy who had committed suicide. Is this unusual? What does it mean?

Following is a poem I wrote for a person I met while we were hospitalized for similar mental conditions. I wrote the poem when I was still in the hospital. She committed suicide by taking an overdose at a time when I still believed all my horrible memories were true. She was a college student, very bright and intelligent with many goals for her life. She believed her parents were active members of the occult and that she had also been a cult member as a child and that now she was in danger because she was talking about it. She had been diagnosed with dissociative and multiple personality disorders. Perhaps for her all this was true, but in light of what happened to me and what has happened to others, I have to wonder if it was true. I will probably never know. What we must consider is, even if she did have a childhood of satanic ritual abuse, even if her parents were still involved, and even if her life was in jeopardy, is this type of therapy effective or is it dangerous? I'm not going to say these activities do not occur in this world. I'm not saying people should not be responsible for themselves. What I am saying is repressed memory therapy appears to make people worse. What I'm saying is that some therapists

justify the worsening condition of their patients by telling them, "You have to get worse before you can get better."

QUESTIONS FOR A FELLOW VICTIM WHO DIDN'T WIN

Why my friend did you have to die,
Why did you give in to that deceitful lie?
Why did you listen to those voices from the past,
Why didn't you see all the pain wouldn't last?
Why did you think only of the hurtful things,
Why couldn't you see the happy times life brings?
Why didn't you fight one more time,
Why did you think your life should be different than mine?

Didn't you think about how afraid I would be,
Didn't you know it would be difficult for me?
Didn't you think about the memories it would start,
Didn't you care they would threaten to tear me apart?
Didn't you think that maybe it would be too much to bear,
Didn't you know those voices would start calling me there?

Didn't you know they were only voices of the past,
Didn't you know what they wanted most you gave them at last?
Didn't you know by giving in they finally would win,
Do you know that now I too am battling to save myself from that sin?

Did you know that I really cared for you my friend:
But I will not let the voices of the past determine my end.

Editor's note: In the past two months, we have been informed by parents of three more suicides. One took place last year and two took place during the past two months. To the best of our knowledge, two of these suicides took place while the people had a full belief in memories that their families say never happened, and one was in the confusing process of questioning the beliefs developed in therapy. Arriving at the time of these reports, the poem and letter from Maria Meyers prompted us to contact our Advisory Board about this matter. A research plan for a preliminary study to determine whether there is anything unusual about the incidence of suicide reports has been designed. We will report on the results as quickly as possible.

BIRDS OF A FEATHER DO NOT ALWAYS FLOCK TOGETHER

To: A Professional and A Mom
From: A Dad and A Professional

Your letter, Rare Bird, in the October 1994 Newsletter presents your perspective, as a professional, about the use of the phrase Recovered Memory Therapy (RMT). As a Social Worker I disagree with your opinion, and there is a factual aspect of your column that requires a response. If the record isn't set straight, readers of the Newsletter may come to believe that the Foundation created that term. I don't believe that to be so. RMT is widely used in various other types of publications, including professional journals, books and texts, and the popular press. When FMSF uses that term, they are using a phrase that has meaning for its readers. I also strongly reject the notion that FMSF is

assigning blame by the use of that term. If others choose to "assign blame", that is their choice. I believe it is important for you to separate the assigning of blame from the analysis of the research and the techniques that have brought so much pain to our children and to families like ours.

You may be targeting the wrong issue in your letter. Clearly, the "...coining of the term RMT" does not remove the obligation of "...good' therapists from responsibility to examine and change their thinking..." (p.9). The NASW Code of Ethics should cover that for us just like other professional codes of ethics speak to our colleagues in the other helping professions. Your energy as it relates to your "Mom" role may be better used with our professional organization. Now that NASW (National Association of Social Workers) has been successful in pushing licensing laws through state legislatures, and the number of states where social workers qualify to receive third-party payments keeps growing, concerned parents and professionals would be well-advised to turn their attention to Continuing Education. The quality of the required continuing education courses should be monitored. At this point, monitoring is virtually non-existent, and the economic benefits to providers of these programs can be vast. Continuing education programs are where RMT and other similar non-scientific notions are spread. Since hypnosis (as well as memory) is not part of a social worker's formal MSW education, I'm certain from your description of your professional use of hypnosis and guided imagery that you are aware of the importance of continuing education as a vehicle for professional development.

Finally, I think it is important that the readers of the Newsletter become aware that not all social workers (or therapists) believe that "Repressed memory questions go to the heart of our cherished beliefs as therapists." (ibid.). If you believe that to be true, I think you should be able to document that statement. Many therapists, including myself, don't know the validity of that concept because of the lack of scientific support for it. I don't hold professional "cherished beliefs" in something that is unproved. I hope I am not in the minority among my colleagues.

Clearing My Name

"I'm sure you understand why I have to clear my name. The consequences of not resolving this accusation before I die is that the whole family and ancestors will suffer."

A Dad (83 years)

Closure

"I have found a closure for what has happened to me. All the families I have talked to all agree that the hardest part of this is that there is no closure. As I began my walk through this valley of loss, I wrote down in a journal my feelings and experiences as they happened. In the last months, I have put into my journal excerpts, dates, other articles, etc. for the day when my grandchildren might want to know what happened to their family. This is now completed, and that has been my way of achieving closure on this part of my life."

A Mom

FMSF Newsletter

"Many thanks for your FMS Foundation's Newsletter. My husband reads it once, deriving some satisfaction in your efforts to turn up the heat on incompetent psychotherapist. I read your Newsletter several times. First, with a blur of tears, sharing the deep hurt with other FMS families; then I tuck the Newsletter into my purse or place it on the snack bar to read and reread it several times before filing it away with past issues."

"Why do I do this? Maybe it's unresolved anxiety or comfort of not being alone or that your Newsletter fills the void of an FMS daughter I have not seen for four years or heard her voice or know where she lives. Many thanks."

A Mom

Won't Talk about Accusation

"My daughter has resumed communication but will not talk about the accusations. It bothers me a great deal because I don't think it is possible to be completely relaxed around anyone if certain subjects are taboo. She is still seeing the same therapist and I am angry that my daughter who does not make very much money has been paying this person \$50 a week for the past four and a half years. Even though not being able to discuss therapy causes there to be an invisible wall between us and I am always on guard because I never know what trouble that therapist will cause next, still I am thankful every day that I am again able to see her and talk with her about the normal part of her life. She still has a wonderful sense of humor."

A Mom

Dear "A Mother"

I have read your letter in the October '94 FMSF Newsletter many times, and I am writing to tell you that you have put into words my own feelings precisely.

My daughter's first assault upon me occurred in the summer of 1989 when I received a series of vicious letters which angrily accused me of vague, unspecified maltreatment. I was absolutely devastated. I won't bother to go into details now, other than to say that I was instructed by her not to contact her for "an indefinite period of time." Her therapist had advised this. And so, the communication ended.

A year later, the letters and accusations began again. This time, I responded only briefly. For three years, I agonized and grieved for my daughter. I couldn't believe she would say and think these things about me.

After three years of nonstop, miserable ruminating, I consulted a therapist myself, a very competent man who, among other things, put me in touch with FMSF. These two events helped me to pull away and really look at what had happened.

In the two years since then, I have had a significant change of heart. I feel very much as you do. By thinking more objectively about her behavior, I came to realize that my daughter, too, had "turned on a bright light" (to use your

"For many families, people (especially accusers) may need to *rebound* before they will be able to *review* what happened."

Margaret Singer, Ph.D

phrase) and forced me to see what a thoroughly self-centered person she was. I also realized that I no longer liked her very much. Like you, I too cherish the memory of my daughter when she was young and when she was growing up. But I do not care for the person who (occasionally) still calls or writes to inform me about how wretched her lot is or how great her suffering, but who refused to take any responsibility for her own life—or acknowledge some of the loss she has caused others, including, I might add, her own children.

Now, after not having seen my daughter for 5 1/2 years, I find that I can get through most days without giving her much thought. I no longer grieve, and (finally) to see other women relating comfortably with their adult daughters no longer cuts me to pieces.

I feel that those of us who have come to the conclusion that you and I have — that it is time to get on with our lives and be done with the past — need all the support we can get. Despite some expressed opinions to the contrary, we both know that this is no easy step to take.

Thank you again for your letter. It needed to be said.

Another Mother

Finding Each Other

"After WWII, the Red Cross and community bulletin boards seemed to be the common ground for people to locate each other. Then, like now, families were separated beyond repair. But, some survived to find each other. And where they went was to common bulletin boards looking for other survivors."

"It seems that retractors call the Foundation because it is their 'Red Cross.' And those of us who have had our families torn from us also call the Foundation because the Foundation has been there for us."

"I doubt if our accusing daughter will ever contact us directly, nor do I expect that. But, if she wanted to, would she be as afraid to contact us as we are to push the issue and contact her? And aren't there others like us?"

"Right now retractors seem to be contacting the Foundation. Could this be the bulletin board that says 'Go ahead and call your parents; they have indicated that they want to communicate?'"

"I don't know the logistics, possibilities, costs, etc. just the availability of databases and the intense desires of parents and probably their children. This is a vague idea but maybe something can be worked out."

"...For myself, I cannot just forgive and forget. Understanding—yes; forgiving—maybe; forgetting—no. No matter how much we miss, or love the daughter that was, we cannot forget that our daughter chose to follow. She chose to destroy. She did not afford us choices in the matter...If she were to call me today, (one of those fantasy dreams), I would expect her to be prepared to admit her own part in this before I could even begin to bridge the gulf between us. It is just as fundamental to the person she was as to the person I have always been."

A Mom

BOOK REVIEW

*Beware the Talking Cure:**Psychotherapy May be Hazardous to Your Health*

by Terence W. Campbell, Ph.D.

ppbk, 265 pages, Upton Books, a division of SIRS \$14.95

Review by Jaye Sharp, Editor of Michigan PFA Newsletter.

"Traditional psychotherapy faces a crisis of enormous proportions," (p 34) writes Dr. Terence Campbell, Michigan clinical and forensic psychologist. Campbell sees little hope for the field of psychotherapy unless it undergoes a radical "paradigm shift." The reader should not be put off by the term "paradigm," although such a reaction would be understandable considering the trivialization it has suffered at the hands of writers of popularized psychobabble. It is a perfectly good and descriptive term and the reader is urged to put aside any negative associations and remember "paradigm" as meaning simply a "model" or "standard".

Science philosopher Thomas S. Kuhn, writes Dr. Campbell, "defines prevailing theories, methods, and procedures of a profession as its 'paradigm.' When the existing paradigm of a profession is no longer viable—as in the case of traditional psychotherapy—a crisis prevails and the profession must undertake a 'paradigm shift.' Otherwise, it jeopardizes its legitimacy as a profession. Once a profession has accomplished a paradigm shift, 'it (quoting Dr. Kuhn)... will have changed its views of the field, its methods, and its goals.'" (pp 34-35)

Briefly, Campbell defines traditional psychotherapy as Analytic therapy, Client center-humanistic (or CC-H) therapy, and Behavioral therapy. Analytic therapy has as its goal a client's insights into his/her own behavior. (p 54) CC-H therapy encourages the client to value getting in touch with feelings as opposed to achieving any intellectual awareness. Behavioral therapy assumes that a client's psychological distress comes from learned patterns of behavior. (p 87) All three therapeutic approaches share the same defect, from Campbell's point of view—in spite of their different approaches—in that they do not adequately serve the client's true needs. The client is, in all three orientations, subservient to therapy ideology. With such traditional psychotherapy, says Campbell, "unless changes in the paradigm of each of these therapeutic orientations occur, there will be no change in views, methods or goals." In other words, until or unless there is change in the theoretical ideology of a therapy, there is no change in the practice of the therapy.

FMS readers may initially be disappointed that Campbell does not cover "recovered-memory" therapy in depth. But this is not within the book's objectives, which are, rather, a critical look at the failures of traditional therapies, an urgent plea for changes within the traditional therapeutic community, and a guide for the lay person seeking therapy.

Recovered-memory therapy is dealt with under "incest-resolution therapy," in Part III of the book: Therapeutic Relationships, Therapist as Prosecutor. This makes sense within the context of the book. Recovered-memory therapy, or as it is referred to in the book, incest resolution therapy, fulfills all the conditions of traditional psychotherapy. It isolates the client from his/her family, makes the therapist the only important person in the client's life, and disregards re-

search in the field while adamantly adhering to a rigid ideology. Not surprisingly, Campbell does not see much hope for a paradigm shift in this area. "... therapists whose professional identities and incomes depend largely on their reputations as 'incest resolution experts' might find it particularly difficult to objectively assess the pitfalls of their orientation." (pp 181-182)

Campbell is scathing in his view of his profession, but not rancorous. At the same time that he condemns traditional psychotherapy (the current paradigm) for its failings, he offers concrete and attainable solutions for "a professional in crisis." He is adamant, for example, in his insistence that the client-therapist relationship needs to be reoriented from a client preoccupation toward a client-family (or significant others) preoccupation. This therapeutic approach enlists the people who are closest to the client—involving them as part of the client's therapeutic solution—and places the therapist in a more peripheral role. (pp 217-218) "Unless psychotherapists undertake the necessary paradigm shift," warns Campbell, "they will reduce themselves to the status of charlatan and faith-healers." (p 245)

Beware the Talking Cure: Psychotherapy May be Hazardous to your Health is above all, a cogent, concise, and relevant guide for anyone thinking about entering therapy. It dispels the confusion and defuses the agony involved in choosing and assessing a therapist. In the book's Afterword, Hiring and Firing a Therapist, the lay person is offered the kind of advice that will save many a potential client a lot of time, money, and anxiety. Campbell insists that potential clients should not hesitate to ask a therapist about his/her training. Such questions, writes Campbell, "are altogether necessary and appropriate. Any therapist who refuses to answer, or responds evasively, is a therapist to avoid." (p 248) For the person already in therapy, there is a list of 40 questions which serves as an invaluable aid in assessing one's own therapeutic experience. If the person in therapy, for example, answers 'yes' to ten or more questions, "you need to carefully question your therapist about the relevance of your therapy..." advises Campbell. "He is probably doing you more harm than good." (p 251) There is an additional implied message here, and that is that the client should assume a less passive role in the client-therapist relationship and accept a greater responsibility in order to insure a successful therapeutic outcome.

Is there hope for a genuine improvement in psychotherapy? "The American public," says Campbell, "deserves more than the illusory effectiveness of wise words, kind words, and encouraging words. Most likely, the impetus for a paradigm shift will come from an informed public demanding it. (Emphasis added) At this point in time, the public possesses greater potential for objectivity about psychotherapy than psychotherapists do. In their dogged determination to protect their obsolete paradigm, traditional therapists have sacrificed their objectivity." (pp 245-246)

Beware the Talking Cure is a book which should be on the shelves of every library and every book store in the country. It will go a long way toward educating consumers about the pitfalls of traditional psychotherapy and informing them about the kinds of mental health services they have a right to demand: effective, constructive therapy from well-trained effective therapists.

New Kind of Memory Found to Preserve Moments of Emotion

by Daniel Goleman

New York Times, Tuesday, October 25, 1994

Reprinted with permission of *The New York Times*.

Do you remember where you went on your first date? Or the most terrifying scene of the last movie that really frightened you? Or what you were doing when you heard the news that the space shuttle Challenger had blown up?

The fact that most people have detailed answers for such questions testifies to the power of emotion-arousing events to sear a lasting impression in memory.

Scientists believe they have now identified the simple but cunning method that makes emotional moments register with such potency: it is the very same alerting system that primes the body to react to life threatening emergencies by fighting or fleeing.

The "fight or flight" reaction has long been known to psychologists: the heart beats faster, the muscles are readied and the body is primed in the most primitive of survival instincts. These and other distinctive reactions are triggered by the release into the bloodstream of the hormones adrenaline and noradrenaline.

The same two hormones, it now appears, also prime the brain to take very special note in its memory banks of the circumstances that set off the flight-or-flight reaction.

The discovery "suggests that the brain has two memory systems, one for ordinary information and one for emotionally charged information," said Dr. Larry Cahill, a researcher at the Center for the Neurobiology of Learning and Memory at the University of California at Irvine. Dr. Cahill and colleagues published the findings in the current issue of the journal *Nature*.

The emotional memory system may have evolved because it had great survival value, researchers say, insuring that animals would vividly remember the events and circumstances most threatening to them.

The findings confirm in humans the relevance of 15 years of research on the neurochemistry of memory with laboratory rats by Dr. James L. McGaugh, director of the Irvine center and a co-author of the paper. His work with animals had implicated adrenaline and noradrenaline in emotional arousal and memory.

"I think it's very exciting," said Dr. Larry Squires, a research scientist specializing in memory at the medical school of the University of California at San Diego. "When you study the effects on a rat's brain of having its foot shocked, you don't really know what emotional state that corresponds to in humans—you could argue its analog in humans is sheer panic. But this suggests it's related to more unusual emotions, like hearing surprising news, being worried or a little scared."

The new experiment depended on use of a drug known to block the effects of adrenaline and noradrenaline and on seeing if it impaired emotion-laden memories in subjects who have been told a horrifying story. In the study volunteers watched a slide presentation with one of two narratives. In the neutral, rather boring version a mother and her son go for a walk to visit his father at the hospital where he works; the story describes the bland details of what he saw

on the way and while he was there.

But in the upsetting version, the boy is critically injured in a terrible accident on the way, and rushed to the hospital, where he is treated for severe bleeding in the brain and a surgical team struggles to re-attach his severed feet.

Before hearing one or another version of the story, half the volunteers received an injection of propranolol, a drug that nullifies the usual effects of adrenaline and noradrenaline by plugging up the receptor sites on the surface of cells that normally respond to the two hormones.

A week later, the volunteers were given a surprise memory test for details of the story. The volunteers who did not get the propranolol remembered more of the upsetting details of the story than the neutral parts, showing that even minor emotional distress enhances memory—a result found in many previous studies.

The key finding was that those volunteers who received the adrenaline-defeating drug were worse at recalling the upsetting details of the story—but not the neutral details—than were those who had no injection. Blocking adrenaline and noradrenaline impaired just the emotional memory of the subjects.

"This is a memory boost system that works in gradations, activating in proportion to the emotional charge," said Dr. Cahill. "We find that it doesn't depend on some intense trauma, but works even when you're just mildly emotionally aroused. But it doesn't activate until there's an emotionally loaded event."

The study is the first to make a definitive bridge to humans from a parallel body of research on emotions and memory in animals. Dr. McGaugh, through a long series of experiments with animals, has pinpointed the amygdala, a pair of walnut-shaped structures that regulate emotion, as the key site where the adrenergic hormones, adrenaline and noradrenaline, affect memory.

"We don't know the precise point of initiation in the brain," said Dr. McGaugh, "but when we get excited about something, a nerve running out of the brain to the adrenals triggers their secretion of adrenaline and noradrenaline." The adrenals are glands that sit on top of the kidneys; when they excrete adrenaline and noradrenaline, the hormones surge through the bloodstream, making the heart beat faster and otherwise priming the body for an emergency.

The adrenaline and noradrenaline appear to activate receptors on the vagus nerve running into the brain. While one job of the vagus nerve is to regulate the heart, it also carries signals to the amygdala. "The noradrenaline activates neurons within the amygdala, which in turn signal other brain regions, presumably cortical areas, to strengthen memory," said Dr. McGaugh. "That's what makes us remember emotionally arousing events so well."

The findings that a minor emotional surge is enough to implant information a bit more firmly in memory might imply, for example, that the anxiety students feel while studying for an exam could itself improve their memory for information—at least to a point. Too much agitation disrupts concentration on what one is trying to read, and so interferes with its registering in memory in the first place.

"Psychologists have said for decades that motivation is important for learning," said Dr. McGaugh. "We'd say excitement is important. In my judgment, it would do no harm

to make learning more exciting."

Another implication is for preventing trauma in people like rescue workers who know they are about to enter an upsetting situation. The fight-or-flight system seems to play a major role in the troubling and intrusive memories that disturb people with post-traumatic stress disorder. "This suggests it might be possible to mute the formation of symptoms by inactivating this system," said Dr. McGaugh. "People like investigators of airplane crashes could take a propranolol-like drug to prevent traumatic memories."

Still another implication is "a modest alert that some people taking beta-blockers for treatments of heart conditions may find the medication attenuates their memory under emotionally arousing conditions," said Dr. McGaugh, referring to the general name for adrenaline-defeating drugs. Other studies of the effects of beta-blockers on memory have come up with mixed results, but its effects specifically on emotional memory have yet to be studied, said Dr. McGaugh.

The findings also suggest that compounds that enhance, rather than block, the effects of adrenaline and noradrenaline might improve memory in humans, Dr. McGaugh said. That possibility is already supported by work with laboratory animals.

Researchers say they are struck by the elegance of the brain's design for memory. "In evolution, this emotional memory system has obvious adaptive value," said Dr. Cahill. "It's very smart of Mother Nature to build a system that remembers things in proportion to how much it helps you survive—like what to eat and what eats you."

LEGAL CORNER

FMSF Staff

Preliminary results of the 1994 FMSF Legal Survey indicate that most civil suits brought on the basis of "recovered repressed memories" of childhood sexual abuse rely almost entirely upon the testimonial of the complainant. Survey results indicate that for an inordinate number of suits no objective corroborating evidence is presented or where evidence is presented, it is found insufficient. Courts, therefore, are faced with determining the intrinsic reliability of the "recovered repressed memories" on which the claims are based. There are serious grounds for doubting their reliability in light of the fact that—

—the scientific community has challenged the assumption that memories of repeated traumatic events may be repressed and then retrieved in pristine form, unaffected by the kind of well-documented distortions known to occur with "normal" recollection;

—many researchers, as well as the American Medical Association, have shown that at least one memory recovery technique, hypnosis, touted by some as effective in recovery of memories of traumatic events, is known to increase suggestibility and confabulation, "memory hardening", source amnesia and a loss of critical judgment. This view has been corroborated by a number of leading clinicians and hypnotherapists;

—clinicians and researchers have warned that a patient's beliefs about the accuracy of a retrieved memory can

be influenced by a therapist's assumptions about memory, repression and hypnosis;

—there is no accepted "litmus test" with which to conduct an internal evaluation of the validity of the memory itself;

—objective corroborative evidence is usually required by competent professionals in clinical practice to determine the validity of the "refreshed" memory.

Hypnosis

Hypnosis is one "memory enhancement technique" around which an extensive case law has developed. In most of these cases, hypnosis was used by a forensic hypnotist to "enhance" the memory of a crime victim or witness. To date, only a few decisions have referred to memories induced after formal hypnosis in a therapeutic setting and every one the author is aware of has been subjected to the criteria of reliability of forensic hypnosis precedents. What have been the concerns of the courts about the reliability of memory "enhanced" by forensic hypnosis? How should those concerns apply to "memory recovery" resulting from hypnosis in therapy?

Hypnosis is being touted as a "powerful" technique to uncover painful memories for victims of childhood trauma.¹ Practitioners of hypnosis in "memory recovery" often cite the need for extraordinary measures to combat the anxiety and defensive mechanism that impede recall of traumatic experiences. In many cases, so much emphasis is placed on the removal of obstacles that the reliability of the technique is not discussed. It is not the place of this report to question the propriety of such assessments in clinical practice, but to focus on the potential use of such recollections as testimony in a court of law. From the importance given hypnosis by memory recovery advocates, we may expect to find hypnosis disclosed in the therapy records of Plaintiffs in increasing numbers of repressed memory cases.

Over a decade of case law has reviewed studies showing how hypnosis may alter a subject's memory, raising questions about its reliability and therefore its admissibility as evidence in court. The rationale given for the effectiveness of hypnosis as a "memory recovery technique" must be juxtaposed against the concerns with the effect of hypnosis on memory as described in professional research, legal cases and law review literature. These concerns include increased suggestibility, tendency to confabulate, possible creation of pseudomemory, a tendency toward "memory hardening", source amnesia and loss of critical judgment. The United State Supreme Court² stated:

"Three general characteristics of hypnosis may lead to the introduction of inaccurate memories: the subject becomes 'suggestible' and may try to please the hypnotist with answers the subject thinks will be met with approval: the subject is likely to 'confabulate', that is, to fill in details from the imagination in order to make an answer more coherent and complete; and the subject experiences 'memory hardening' which gives him great confidence in both true and false memories, making effective cross-examination

1. Herman, J. (1992) *Trauma and Recovery*. Basic Books.

2. *Rock v Arkansas*, 483 U.S. 44, 62, 97 L.Ed.2d 37, 107 S.Ct.2704 (1987).

more difficult."

Other courts³ have, after extensive review of relevant scientific studies, considered the following six areas potential problems for the reliability of a memory which was the subject of a hypnosis session:

1. A person in a hypnotic trance is subject to a heightened degree of suggestibility. The source of the suggestion could be subtle verbal or nonverbal cues of which even the hypnotist is not aware. Such suggestion may be of particular concern when the hypnotist is not a "neutral" party. Suggestions may be heightened by the subject's perception that hypnosis will provide a more accurate recall or by a desire to please the hypnotist.

2. Confabulation may occur when an individual remembers part of the event and fills in the missing gaps in his or her memory with incorrect or inaccurate information. These additions, while plausible, may consist of facts taken from an unrelated prior experience or from fantasy. It is impossible for anyone, including the subject or a psychiatrist or psychologist with extensive training in the field of hypnosis, to determine whether a particular piece of information is actual memory or confabulation, absent independent verification.

3. Hypnosis may create a "pseudomemory" in the hypnotized individual. The vividness of hypnotic recall can give the impression of being a real memory. Thus after being hypnotized, the individual may falsely believe his post-hypnotic recall of the event accurately reflects the event itself.

4. "Memory hardening" refers to the subjective conviction that the memory after hypnosis is accurate in every detail, and beyond even the fallibility most subjects are willing to concede in day-to-day memory recollection. Memory hardening is exacerbated by certain factors. Before being hypnotized the subject may be told (or believe) that hypnosis will help her/him to remember very clearly only truthful facts about an event and that the subject will not interject any fantasies. During the trance s/he may be given the suggestion that after s/he awakes s/he will be able to remember the event clearly and comprehensively. Some lay hypnotists have maintained that such suggestions actually guard against the process of confabulation because subjects obey them to the letter. There is little evidence that such communications will eliminate the inaccuracies: they are likely to remain the same with or without the suggestions. The effect, in fact, may be to ensure uncritical acceptance of the pseudomemory.

Many jurisdictions have noted that the memory-hardening phenomenon may eliminate fear of perjury as a factor ensuring reliable testimony. Additionally, effective cross examination may be seriously impeded, when the witness cannot distinguish between facts known prior to hypnosis, facts confabulated during hypnosis to produce pseudomemories, and facts learned after hypnosis.

3. The points noted here are taken directly from decisions which quoted relevant scientific findings. For an extensive listing of decisions and jurisdictions which have reviewed these concerns in making admissibility determinations, see FMSF Summary of Legal Resources, 1994 edition which may be ordered from the FMS Foundation.

5. Another serious problem in the translation of belief into memory in a hypnotic session is source amnesia. The subject may confound memories evoked under hypnosis with prior recall, believing that what was post-hypnotic memory was known all along. When this happens, it is impossible to go back and recreate the subject's pre-hypnotic memory. Very often hypnotic subjects have refused to believe they actually went into a trance, others claim they were only pretending to be hypnotized.

Many jurisdictions conclude that only independent verification of what the subject says can distinguish between the accurate and the inaccurate. Many also insist that accurate records be made of the subject's pre-hypnosis memories to aid in the determination of reliability and admissibility.

6. Researchers have shown that hypnosis allows a subject to lower her/his critical judgment, becoming more willing to accept suggestion as s/he is more willing to please her/his hypnotist. S/he may also be more apt to speculate about the details of an experience and more willing to engage uncritically in fantasy and role playing.

The courts have taken three main approaches to admission of hypnotically-enhanced testimony. The approach adopted by a particular jurisdiction generally reflects its perception of the degree to which the problems with hypnosis affect a person's memory of an event. Regardless of the approach followed, testimony based on memory created and induced solely under hypnosis where no memory existed prior to the hypnotic interview and where no independent objective corroboration is presented, has been rejected. The use of hypnosis as a sort of "lie detector test" has also been rejected. (The most recent edition of the FMSF Summary of Legal Resources reviews relevant case law and includes cites to professional research and law review articles related to the admissibility of post hypnosis testimony.) These approaches can be summarized as follows:

1. The first approach⁴ establishes a *per se* rule excluding any hypnotically refreshed or enhanced testimony at trial. However, even under this rule some jurisdictions may allow the previously hypnotized witness to testify about the details of events that are demonstrably recalled prior to undergoing hypnosis. The burden is on the offering party to show the extent of the testimony recalled without the aid of hypnosis and in some courts to show that the new evidence has met the Frye standard. The rationale in most of the cases adopting a *per se* exclusion rule is derived from the admissibility requirement for scientific evidence set by the United States Supreme Court in Frye v United States.⁵

4. See decisions from Alaska, Arizona, Arkansas, California, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Utah, Virginia and Washington.

5. Frye v United States, 54 App.D.C. 46, 293 F. 1013 (1923) sets the standard for acceptance of scientific evidence, admitting only if the offered evidence has met general acceptance in the relevant scientific community. The purpose of this standard, where applied, is to prevent the jury from being misled

2. The second approach⁶ admits such testimony, holding that hypnosis affects the weight and credibility of hypnotically-refreshed testimony, not its admissibility. Credibility and weight are to be determined at trial by cross-examination of the witness, based on expert testimony or aided by cautionary instructions to the jury. A basic tenet of this approach is that hypnotically-enhanced recall is similar to ordinary recall and where differences exist they are only a matter of degree. In other words, jurisdictions following this view find that hypnotically-refreshed testimony is not inadmissible as a matter of constitutional law.

3. The third approach⁷ holds that hypnosis may affect reliability of hypnotically-refreshed testimony and admits such testimony as long as the party offering the testimony establishes compliance with certain procedural safeguards. Related to this approach are the jurisdictions which consider reliability of the testimony on a "case-by-case" or "totality of the circumstances" basis. Under this approach, procedural safeguards as well as other factors are considered with the intent of balancing the inherent dangers of hypnotically refreshed testimony against the testimony's reliability. The safeguards suggested are used by trial courts to determine reliability and subsequent admissibility. Hypnotic testimony from a session which follows the suggested guidelines is not automatically admissible, nor is testimony automatically inadmissible where all possible safeguards were not followed.⁸ A listing of some of the safeguards considered by the courts is given below. Not every court has considered each of these, although courts contemplating admission under the "totality of the circumstances" basis are likely to have done so. Again, see the FMSF Summary of Legal Resources for related case cites. Safeguards considered include:

- whether the hypnotist is a licensed, qualified psychiatrist or psychologist trained in the use of hypnosis and aware of its possible effects on memory so as to be able to aid in the prevention of improper suggestions and confabulation;

- whether the hypnotist is neutral with little investment in the ultimate disposition of the case. The qualified professional should have minimal preconceptions about the case;

- any information given to the hypnotist prior to the session should be noted in writing so that subsequently the extent of information that the subject received from the

by unproven and unsound scientific methods. The courts hold that the method hypnosis has not gained general acceptance in the relevant scientific community, nor can the enhanced memory, which is a product of the method, be accepted.

6. See decisions from First Circuit, Third Circuit, Ninth Circuit, Tenth Circuit, Louisiana, Mississippi, North Dakota, Tennessee, Wyoming.

7. See decisions from Idaho, New Jersey, New Mexico, Texas, Wisconsin, Fifth Circuit, Eighth Circuit.

8. Several courts have rejected the "case-by-case" safeguards approach, noting that safeguards refer to only one of the potential problems with hypnosis, that of suggestibility. The other problems affecting reliability can be neither limited nor measured by the safeguards suggested.

hypnotist may be determined;

- a detailed record should be made of pre-hypnosis description by the subject to determine whether the hypnotic interview affected the memory of the witness;

- the session should be recorded, and preferably videotaped, so that a permanent record is available to the court to determine the nature of the questioning and the existence of any suggestive procedures;

- evaluation of any discernible motivation the subject may have for remembering or forgetting the events in question;

- the amount of confidence the witness had in his initial recollection and whether hypnosis so enhanced the witness' confidence in his original recollection that the opposing party's right to cross-examine has been substantially and materially impaired;

- the appropriateness of using hypnosis to restore memory loss in this case;

- the existence of corroborating evidence independent of the proposed testimony.

How will the higher courts respond to the reliability of repressed memory claims? Can the clinical needs of exploring "narrative truth" be reconciled with the courts' requirements for "historical truth"? Part II of this article, to appear in a subsequent newsletter, will review the reasoning of courts which have considered the reliability of testimony which was the subject of therapeutic hypnosis.

In the words of Judge J. Wright⁹:

"Psychotherapists who engage in recovered memory methods are considered either forensic or clinical. Each group uses different techniques in attempting to retrieve a repressed memory because each group is attempting to accomplish something fundamentally different. The forensic psychotherapist is typically trying to elicit information that will be admissible at trial and, therefore, will not 'prepare' the patient, make suggestions, or ask leading questions during therapy. The clinician's purpose, however, is completely different. The clinician's goal is rehabilitation. The treatment program is provided solely to benefit the patient. If a patient's rehabilitation can be accomplished by assisting that patient to recall a traumatic memory heretofore repressed, whether the memory is fact or fantasy, the clinician will encourage the patient to recall that memory in whatever form. For it is not necessarily the recalling of an accurate memory with which the clinician is concerned, but with the patient's overall rehabilitation. For example, in attempting to rehabilitate patients by helping them recall a traumatic memory, clinicians may reveal their own expectations before the session about the information they expect to recover, ask leading questions, and encourage patients to use their imagination. None of these techniques is appropriate in the forensic setting. . . . The practice of memory recovery is fraught with unreliability and, when used in the judicial system, should receive. . . skepticism and critical examination."

Part II of this article will appear in a subsequent newsletter.

9. Ault v Jasko, 70 Ohio St. 3d 114; 637 N.E.2d 870; 1994. Judge J. Wright for the dissent. Ohio LEXIS 1840 (Ohio Supreme Court, 1994).

FMSF Fundraising Drive

When the FMS Foundation began, we really didn't have any understanding of the scope of the problem that would be exposed. We wanted to learn what was causing our children to rewrite their histories, to do cruel things and to cut off contact. We wanted to find ways to reach our children. We wanted to go out of business.

As we consider the strides we have made along with the things that still need to be done, it has become clear that we should stick around. The job is not done. If that is the case, then we need to plan. The Foundation has been existing on a financial "hand-to-mouth" status. Our critics' claims notwithstanding, stories of our great wealth are as fantastic as the stories of alien abduction or satanic cult abuse. We are, therefore, going to start a fund-raising drive.

The Foundation directors have asked Charles Caviness to assume the leadership in a fund raising effort. Charles, a vice president and financial consultant with a major brokerage house, has been an active member in his local area and at the state level in California. He is active in his home area in various secular and religious-affiliated philanthropic areas and brings a wealth of experience to this important volunteer role. Currently, along with a small planning committee, Charles is completing the final preparation for the effort to contact people who have been involved with the Foundation. When he or his volunteers gets in touch with you, please be as generous as you can.

Confidentiality: Because of FMSF policies about strict confidentiality, the Foundation cannot use many of the standard fund-raising strategies of ordinary organizations. It's a dilemma and a challenge. We count on your help and your resolve to put an end to this nonsense

This issue is the last newsletter of 1994. Members, however, will soon receive a copy of a new FMSF booklet, "Frequently Asked Questions." We hope you will write with suggestions for improving it.

Happy Holidays

MEMORY AND REALITY: RECONCILIATION CONFERENCE TAPES

The Memory and Reality: Reconciliation conference will be professionally videotaped and audiotaped by Aaron Video Company. When tapes are available, you will be able to order directly from Aaron Video. Information about ordering tapes and the cost of the tapes will appear in the January 1995 FMSF Newsletter.

Aaron Video, 6822 Parma Park Blvd., Parma, OH 44130

FMS FOUNDATION and JOHNS HOPKINS MEDICAL INSTITUTIONS

present

MEMORY AND REALITY: RECONCILIATION

Scientific, Clinical and Legal Issues of False Memory Syndrome

December 9 - 11, 1994

Stouffer Harborplace Hotel, Baltimore, Maryland

PROGRAM

THURSDAY, DECEMBER 8, 1994

6-8 pm Registration, Stouffer Harborplace Hotel, Fifth Floor Foyer

FRIDAY, DECEMBER 9, 1994

7:15 Registration and Coffee, Fifth Floor Foyer

8:00 WELCOME AND OPENING REMARKS

Pamela P. Freyd, Ph.D.

Paul R. McHugh, M.D.

8:15 SCIENTIFIC ISSUES—NATURE OF MEMORY

Chair: David S. Holmes, Ph.D.

KEYNOTE ADDRESS: SCIENTIFIC FINDINGS ON MEMORY DISTORTION

Elizabeth F. Loftus, Ph.D.

9:00 OVERVIEW OF RESEARCH ON MEMORY DISTORTION

Daniel L. Schacter, Ph.D.

9:30 Refreshment Break

9:45 ADULT MEMORIES OF CHILDHOOD SEXUAL ABUSE

Linda Meyer Williams, Ph.D.

10:15 PSYCHOTHERAPISTS' BELIEFS ABOUT RECOVERED MEMORIES

D. Stephen Lindsay, Ph.D.

10:45 MEMORY SYSTEMS OF THE BRAIN

Larry R. Squire, Ph.D.

11:15 DISCUSSION

11:30 Lunch (on your own)

12:45 SCIENTIFIC ISSUES—SUGGESTIBILITY AND INFLUENCE

Chair: Campbell Perry, Ph.D.

KEYNOTE ADDRESS: INFLUENCE IN PSYCHOTHERAPY —THE BIG PICTURE

Richard J. Ofshe, Ph.D.

1:30 HERMENEUTIC REASONING: A DOUBLE-EDGED SWORD

Phillip F. Slavney, M.D.

2:00 FALSE MEMORY SYNDROME: AN ANTHROPOLOGICAL PERSPECTIVE

Michael G. Kenny, Ph.D.

2:30 HISTORICAL AND NARRATIVE TRUTH

Donald P. Spence, M.D.

3:00 DISCUSSION

3:15 Refreshment Break

3:30 CLINICAL ISSUES—CONSEQUENCES OF IGNORING SCIENCE

Chair: Harold I. Lief, M.D.

DEMOGRAPHIC AND DESCRIPTIVE ASPECTS OF RETRACTORS

Harold I. Lief, M.D.

Janet M. Felkewicz

3:55 WHEN MEMORIES INTERFERE WITH INSIGHT IN PSYCHOTHERAPY

George K. Ganaway, M.D.

4:20 APPROPRIATE AND INAPPROPRIATE THERAPY IN RECOVERED MEMORY THERAPY

Margaret T. Singer, Ph.D.

4:45 DISCUSSION

5:00 Formal Program Adjourns

5:15 INFORMAL DISCUSSION GROUPS/POSTER SESSIONS

Coordinators: Allen Feld, M.S.W.

Joseph de Rivera, Ph.D.

SATURDAY, DECEMBER 10, 1994

7:15 Coffee

8:00 CLINICAL ISSUES—STANDARDS OF CARE

Chair: August T. Piper, Jr., M.D.

KEYNOTE ADDRESS: THE DO'S AND DON'TS FOR THE CLINICIAN MANAGING MEMORIES OF ABUSE

Paul R. McHugh, M.D.

9:00 BELIEF IN THE PATIENT?

Harold Merskey, D.M.

9:30 CHILDHOOD SEXUAL ABUSE AND ADULT PSYCHIAT- RIC DISORDERS: A REVIEW OF THE EVIDENCE

James I. Hudson, M.D.

Harrison G. Pope, Jr., M.D.

10:00 DISCUSSION

10:15 Refreshment Break

10:30 CLINICAL ISSUES—RECONCILIATION

Chair: John Hochman, M.D.

KEYNOTE ADDRESS: FALSE MEMORY, DISSOCIATION AND PSEUDOIDENTITY

Louis Jolyon West, M.D.

11:30 REINTEGRATING FAMILIES

Paul W. Simpson, Ph.D.

11:50 EXPERIENCES WITH REBUILDING FAMILIES

Saul Wasserman, M.D.

12:15 DISCUSSION

12:30 Lunch (on you own)

1:45 LEGAL ISSUES—FROM THE PLAINTIFF'S TABLE

Chair: Andre W. Brewster, Esq.

KEYNOTE ADDRESS: MEMORY AND TRUTH

Richard Harrington, J.D.

2:30 REPRESENTING THE PRIMARY VICTIM

Skip Simpson, J.D.

3:00 STATUS OF LAWSUITS

Anita J. Lipton

3:15 DISCUSSION

3:25 Refreshment Break

3:35 LEGAL ISSUES—FROM THE DEFENSE TABLE

Chair: Richard Green, M.D., J.D.

DEFENDING THE FALSELY ACCUSED

Alan D. Gold, Barrister

4:00 CONSEQUENCES OF THE THERAPIST'S CLAIM, "I'M NOT A DETECTIVE"

Steven P. Moen, J.D.

4:25 EVIDENTIARY CONSIDERATIONS RELATIVE TO THE USE OF REPRESSED MEMORY THEORIES

Andrew J. Graham, J.D.

4:50 DISCUSSION

5:00 Formal Program Adjourns

5:15 INFORMAL DISCUSSION GROUPS/POSTER SESSIONS

Coordinators: Allen Feld, M.S.W.

Joseph de Rivera, Ph.D.

SUNDAY, DECEMBER 11, 1994

8:00 Coffee

8:30 LEGAL ISSUES—RIGHTS OF SOCIETY

Chair: Loren Pankratz, Ph.D.

DUTY OF CARE TO THIRD PERSONS

Ralph Slovenko, J.D., Ph.D.

MEMORY RECOVERY THERAPY: COSTLY CARE FOR NEGATIVE GAIN

Douglas E. Mould, Ph.D.

GOOD NEWS / BAD NEWS—THE BURDEN IS OURS

Terence W. Campbell, Ph.D.

10:15 Refreshment Break

10:30 EDUCATIONAL ISSUES—NEED FOR CHANGE

Chair: Robyn M. Dawes, Ph.D.

EDUCATIONAL ISSUES IN PSYCHIATRY

Paul R. McHugh, M.D.

EDUCATIONAL ISSUES IN SOCIAL WORK

Carolyn Saari, Ph.D.

EDUCATIONAL ISSUES IN PSYCHOLOGY

Lee Sechrest, Ph.D.

12:15 BECOME PART OF THE SOLUTION

Pamela P. Freyd, Ph.D.

Paul R. McHugh, M.D.

1:00 Conference Adjourns

SMALL GROUP SESSIONS - Tentative

Registration for these sessions will be done at the conference.

Sons as Accusers

Model legislation

Self-care tips for the falsely accused

Dealing with state licensing boards

Families being sued: A proactive stance

Mediation and trial preparation

For families new to FMS

Meeting with your child's therapist

Reconciliation area

Family's experience with reconciliation

Retractor meeting

Courage to stand: A parent's experience on being sued.

Dealing with the media

From MPD to DID: New names—old problems

Living with False Memory Syndrome

State contact meeting

Spouses of the accused

Meeting of social workers

How to find a lawyer

Experiencing religious counseling

Canadian families meeting

Siblings caught in the middle

FMSF MEETINGS**FAMILIES, RETRACTORS & PROFESSIONALS
WORKING TOGETHER****STATE MEETINGS****WASHINGTON STATE**

3-Day Seminar: November 4, 5, 6, 1994
"Current Topics in the Law and Mental Health"

presented by Missoula Psychiatric Services
THE WESTIN HOTEL, SEATTLE
Call 406-542-7526 for information

NORTHERN CALIFORNIA**REGIONAL MEETING**

Lunch meeting, November 19, 1994
Guest speaker: Richard Ofshe, Ph.D.
author of *Making Monsters*
Call San Francisco/Bay Area contacts
for information.

SOUTHERN CALIFORNIA**REGIONAL MEETING**

Lecture - Friday, December 2, 1994 - 7 pm
Guest speaker: Larry Hedges, Ph.D.
distinguished psychoanalyst & author of
*Remembering, Repeating and Working
Through Childhood Trauma*
Call Chris or Alan (714) 733-2925 for information.

UNITED STATES

Call person listed for meeting time & location.
key: (MO) = monthly; (bi-MO) = bi-monthly

ARKANSAS - AREA CODE 501

LITTLE ROCK
Al & Lela 363-4368

CALIFORNIA**NORTHERN CALIFORNIA**

SACRAMENTO/CENTRAL VALLEY - BI-MONTHLY
Charles & Mary Kay (916) 961-8257

SAN FRANCISCO & BAY AREA - BI-MONTHLY

EAST BAY AREA
Judy (510) 254-2605

SAN FRANCISCO & NORTH BAY
Gideon (415) 389-0254

Charles (415) 984-6626 (day); 435-9618 (eve)

SOUTH BAY AREA
Jack & Pat (408) 425-1430

Last Saturday, (Bi-MO)
CENTRAL COAST
Carole (805) 967-8058

SOUTHERN CALIFORNIA

BURBANK (formerly VALENCIA)
Jane & Mark (805) 947-4376

4th Saturday (MO) 10:00 am
CENTRAL ORANGE COUNTY

Chris & Alan (714) 733-2925
1st Friday (MO) - 7:00 pm

ORANGE COUNTY (formerly LAGUNA BEACH)
Jerry & Eileen (714) 494-9704

3rd Sunday (MO) - 6:00 pm
COVINA GROUP (formerly RANCHO

CUCAMONGA)
Floyd & Libby (818) 330-2321

1st Monday, (MO) - 7:30 pm
WEST ORANGE COUNTY

Carole (310) 596-8048
2nd Saturday (MO)

COLORADO

DENVER
Ruth (303) 757-3622
4th Saturday, (MO) 1:00 pm

CONNECTICUT - AREA CODE 203

NEW HAVEN AREA
George 243-2740

FLORIDA

DADE-BROWARD AREA
Madeline (305) 966-4FMS

DELRAY BEACH PRT
Esther (407) 364-8290
2nd & 4th Thursday [MO] 1:00 pm

ILLINOIS

CHICAGO METRO AREA (South of the
Eisenhower)
2nd Sunday [MO] 2:00 pm
Roger (708) 366-3717

INDIANA

INDIANAPOLIS AREA (150 mile radius)
Gene (317) 861-4720 or 861-5832
Nickie (317) 471-0922 (phone & fax)

IOWA

DES MOINES
Betty/Gayle (515) 270-6976

KANSAS

KANSAS CITY
Pat (913) 738-4840 or Jan (816) 931-1340
2nd Sunday (MO) EXCEPT DECEMBER

KENTUCKY

LEXINGTON
Dixie (606) 356-9309

LOUISVILLE

Bob (502) 957-2378
Last Sunday (MO) 2:00 pm

MAINE - AREA CODE 207

BANGOR
Irvine & Arlene 942-8473

FREEMPORT

Wally 865-4044
3rd Sunday (MO)

YARMOUTH

Betsy 846-4268

MARYLAND

ELLICOTT CITY AREA
Margie (410) 750-8694

MASSACHUSETTS / NEW ENGLAND

CHELMSFORD
Jean (508) 250-1055

MICHIGAN

GRAND RAPIDS AREA - JENISON
Catharine (616) 363-1354
2nd Monday (MO)

MINNESOTA

ST. PAUL
Terry & Collette (507) 642-3630

MISSOURI

KANSAS CITY
Pat (913) 738-4840 or Jan (816) 931-1340
2nd Sunday (MO)

ST. LOUIS AREA

Karen (314) 432-8789
3rd Sunday [MO] 1:30 pm
Retractors support group also meeting.

SPRINGFIELD - AREA CODES 417 AND 501

Dorothy & Pete (417) 882-1821
Nancy & John (417) 883-4873
4th Sunday [MO] 5:30 pm

NEW JERSEY (So.)-See PENNSYLVANIA (WAYNE)

NEW YORK - UPSTATE / ALBANY AREA
Elaine (518) 399-5749

OHIO

CINCINNATI
Bob (513) 541-5272

OKLAHOMA - AREA CODE 405

OKLAHOMA CITY
Len 364-4063 Dee 942-0531
HJ 755-3816 Rosemary 439-2459

PENNSYLVANIA

HARRISBURG AREA
Paul & Betty (707) 761-3364

PITTSBURGH

Rick & Renee (412) 563-5616

WAYNE (includes So. Jersey)

Jim & Joanne (610) 783-0396
No further meetings until March, 1995

TEXAS**CENTRAL TEXAS**

Nancy & Jim (512) 478-8395

DALLAS/FT. WORTH

Lee & Jean (214) 279-0250

HOUSTON

Jo or Beverly (713) 464-8970
Wednesday, November 2, 7:30 pm
Speaker: Eleanor Goldstein

VERMONT & UPSTATE NEW YORK

Elaine (518) 399-5749

WISCONSIN

Katie & Leo (414) 476-0285

CANADA**BRITISH COLUMBIA****VANCOUVER & MAINLAND**

Ruth (604) 925-1539
Last Saturday (MO) 1:00-4:00 pm

VICTORIA & VANCOUVER ISLAND

John (604) 721-3219
3rd Tuesday (MO) 7:30 pm

MANITOBA**WINNIPEG**

Muriel (204) 261-0212
1st Sunday (MO)

ONTARIO**OTTAWA**

Eileen (613) 592-4714

TORONTO

Pat (416) 444-9078
Saturday, November 26 (Bi-MO)

AUSTRALIA

Ken & June, P O Box 363, Unley, SA 5061

NETHERLANDS

Task Force False Memory Syndrome of
"Ouders voor Kinderen"
Mrs. Anna de Jong, (0) 20-693 5629

NEW ZEALAND

Mrs. Colleen Waugh, (09) 416-7443

UNITED KINGDOM

The British False Memory Society
Roger Scotford (0225) 868-682

...

Deadline for JANUARY 1995 Issue:
Friday, December 16

Do you have access to e-mail? Send a message to pjf@cis.upenn.edu if you wish to receive electronic versions of this newsletter and notices of radio and television broadcasts about FMS. All the message need say is "add to the FMS list". It would be useful, but not necessary, if you add your full name (all addresses and names will remain strictly confidential).

The False Memory Syndrome Foundation is a qualified 501(c)(3) corporation with its principal offices in Philadelphia and governed by its Board of Directors. While it encourages participation by its members in its activities, it must be understood that the Foundation has no affiliates and that no other organization or person is authorized to speak for the Foundation without the prior written approval of the Executive Director. All membership dues and contributions to the Foundation must be forwarded to the Foundation for its disposition.

RATE INCREASE - Nov 1, '94 The FMSF Newsletter is published 10 times a year by the False Memory Syndrome Foundation. A subscription is included in membership fees. Others may subscribe by sending a check or money order, payable to FMS Foundation, to the address below. 1995 subscription rates: USA: 1 year \$30, Student \$10; Canada: 1 year \$35; (in U.S. dollars); Foreign: 1 year \$40. (Single issue price: \$3 plus postage.)

What IF?

What if, parents who are facing lawsuits and want legal information about FMS cases, had to be told, "I'm sorry, there isn't any such thing available?"

What if, your son or daughter began to doubt his or her memories and called FMSF only to get a recording, "This number is no longer in operation?"

What if, a journalist asks you where to get information about the FMS phenomenon, and you had to answer, "Sorry, I don't know?"

What if, you want to ask a question that only an expert, familiar with FMS can answer, and find out that FMSF can no longer provide that information? Where would you turn?

What if the False Memory Syndrome Foundation did not exist? A frightening thought, isn't it?

Please support our Foundation. We cannot survive without your support!

Reprinted from the August 1994 PFA (MI) Newsletter

YEARLY FMSF MEMBERSHIP INFORMATION

Professional - Includes Newsletter \$125 _____
Family - Includes Newsletter \$100 _____
Additional Contribution: _____

___ Visa: Card # & expiration date: _____
___ Mastercard: Card # & expiration date: _____
___ Check or Money Order: Payable to FMS Foundation in U.S. dollars

Please include: Name, address, state, country, phone, fax

FMS Foundation

3401 Market Street, Suite 130 Philadelphia, PA 19104-3315

Phone 215-387-1865

ISSN # 1069-0484

Pamela Freyd, Ph.D., Executive Director
FMSF Scientific and Professional Advisory Board

November 1, 1994

Terence W. Campbell, Ph.D., Clinical and Forensic Psychology, Sterling Heights, MI; Rosalind Cartwright, Ph.D., Rush Presbyterian St. Lukes Medical Center, Chicago, IL; Jean Chapman, Ph.D., University of Wisconsin, Madison, WI; Loren Chapman, Ph.D., University of Wisconsin, Madison, WI; Robyn M. Dawes, Ph.D., Carnegie Mellon University, Pittsburgh, PA; David F. Dinges, Ph.D., University of Pennsylvania, The Institute of Pennsylvania Hospital, Philadelphia, PA; Fred Frankel, M.B.Ch.B., D.P.M., Beth Israel Hospital, Harvard Medical School, Boston, MA; George K. Ganaway, M.D., Emory University of Medicine, Atlanta, GA; Martin Gardner, Author, Hendersonville, NC; Rochel Gelman, Ph.D., University of California, Los Angeles, CA; Henry Gleitman, Ph.D., University of Pennsylvania, Philadelphia, PA; Lila Gleitman, Ph.D., University of Pennsylvania, Philadelphia, PA; Richard Green, M.D., J.D., Charing Cross Hospital, London; David A. Halperin, M.D., Mount Sinai School of Medicine, New York, NY; Ernest Hilgard, Ph.D., Stanford University, Palo Alto, CA; John Hochman, M.D., UCLA Medical School, Los Angeles, CA; David S. Holmes, Ph.D., University of Kansas, Lawrence, KS; Philip S. Holzman, Ph.D., Harvard University, Cambridge, MA; John Kihlstrom, Ph.D., Yale University, New Haven, CT; Harold Lief, M.D., University of Pennsylvania, Philadelphia, PA; Elizabeth Loftus, Ph.D., University of Washington, Seattle, WA; Paul McHugh, M.D., Johns Hopkins University, Baltimore, MD; Harold Merskey, D.M., University of Western Ontario, London, Canada; Ulric Neisser, Ph.D., Emory University, Atlanta, GA; Richard Ofshe, Ph.D., University of California, Berkeley, CA; Martin Orne, M.D., Ph.D., University of Pennsylvania, The Institute of Pennsylvania Hospital, Philadelphia, PA; Loren Pankratz, Ph.D., Oregon Health Sciences University, Portland, OR; Campbell Perry, Ph.D., Concordia University, Montreal, Canada; Michael A. Persinger, Ph.D., Laurentian University, Ontario, Canada; August T. Piper, Jr., M.D., Seattle, WA; Harrison Pope, Jr., M.D., Harvard Medical School, Cambridge, MA; James Randi, Author and Magician, Plantation, FL; Carolyn Saari, Ph.D., Loyola University, Chicago, IL; Theodore Sarbin, Ph.D., University of California, Santa Cruz, CA; Thomas A. Sebeok, Ph.D., Indiana University, Bloomington, IN; Louise Shoemaker, Ph.D., University of Pennsylvania, Philadelphia, PA; Margaret Singer, Ph.D., University of California, Berkeley, CA; Ralph Slovenko, J.D., Ph.D., Wayne State University Law School, Detroit, MI; Donald Spence, Ph.D., Robert Wood Johnson Medical Center, Piscataway, NJ; Jeffrey Victor, Ph.D., Jamestown Community College, Jamestown, NY; Hollida Wakefield, M.A., Institute of Psychological Therapies, Northfield, MN; Louis Jolyon West, M.D., UCLA School of Medicine, Los Angeles, CA.

FMS Foundation
3401 Market Street - suite 130
Philadelphia, PA 19104-3315

NON-PROFIT ORG.
U. S. POSTAGE
PAID
PHILA., PA
PERMIT NO. 1408

TIME DATED MATERIAL

Attn. All Members!!

To speed the arrival of newsletters,
please ask your postmaster for your

ZIP+4 code.

Send it ASAP along with your
name and address clearly marked

on a postcard to FMSF,

Attn: Nick. Thank you.

We must hear from everyone
for this effort to work!